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# TREATMENT OF THE INSANE.

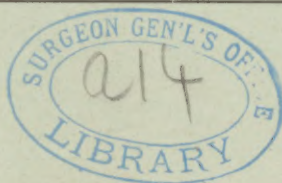


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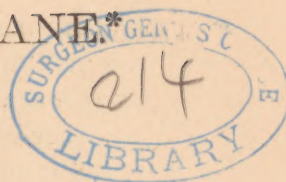




# TREATMENT OF THE INSANE.\*

By ORPHEUS EVERTS, M. D.,

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Notwithstanding the common belief of Christendom that all manifestations of mind are effected by immaterial, intelligent, and immortal, beings temporarily associated with our poor mortal bodies, we are compelled to refer all disorderly manifestations to some defect, or depravity, of these same perishable and helpless elements.

This we do, not only because science so instructs us—but because to ascribe mania, melancholia or dementia, to such hypothetical beings—souls or spirits—would be inconsistent with cherished ideas respecting the origin, constitution, and destiny, of such beings—and might detract from the pleasing assurance that “all the ills that flesh is heir to” will be left behind, when “this muddy vesture of decay” no longer “shuts us in.”

I shall refrain, therefore, in presenting this report, from speaking of insanity as a disease of “the mind”—or immaterial man—inasmuch as such use of words is no longer justified by facts or theories—and I shall, also, at the risk of being regarded as “more nice than wise,” adopt the phrase—Treatment of the Insane—instead of—Treatment of Insanity.

There are two classes of insane persons, the curable and the incurable, that may be treated, in some respects, quite differently, with propriety.

A proper treatment of the curable class is a matter of

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great interest to all, but more especially so to members of the medical profession.

Treatment of the incurable, however interesting to the medical man, as a citizen, may as well be delegated to professional philanthropists and political economists, whether educated as physicians or otherwise.

It may be understood, therefore, in advance, that the recommendations and suggestions to follow in this report, pertain to the treatment of such of the insane as are supposed to be curable by treatment; any allusion to the other class being simply incidental.

I shall assume that the physician called upon to treat the insane, is capable of differentiating the curable from the incurable; or, if not, that he will treat all doubtful cases, tentatively, as if curable.

I shall assume, also, notwithstanding the claim of notable physicians to the contrary, that much the larger portion of the insane are incurable, even at the time when mental disorder is first discoverable by ordinary observers.

Just what the relative number of the incurable to the whole number of the insane is, I am not prepared to state. Modern hospital reports indicate a failure to cure at least sixty per cent of the whole number admitted to hospitals for treatment; and it is presumable that a ratio of cures based upon the whole number of insane, for any given period, would indicate a much larger percentage of failure.

The number of persons usually reported "cured," whose conditions represent only a kind of compromise between constructive and destructive activities, a restoration of order upon a lower plane of structural and functional capabilities, with a doubtful future, is worthy, also, of consideration.

The unknown quantity in this problem, which I may estimate at too low a figure, is the number of those who

become incurable from neglect, or improper treatment of any kind.

But the question of numbers, or the relative proportion of the curable to the incurable, is not important as bearing upon the treatment of the insane, of either class.

It has been, for a long time, taught and believed, by physicians and others, that the probabilities of recovery of insane patients are much increased by sending them to hospitals for the insane for treatment, at any time before the conditions of disorder become chronic.

Upon what basis of facts this claim rests, if upon any, I do not know. It is inferentially correct, however, and I shall regard it as true.

If not true—if hospital methods and appliances are not superior to home methods and appliances in the treatment of the curable insane—then much that is to follow in this report is without significance.

If true—if hospital methods and appliances effect better general results than do other known methods and appliances—the question at once arises: What are the distinctive features of hospital treatment, upon which its superiority depends?

That the greater success of hospital treatment of the insane, as contrasted with home treatment, is attributable to any superiority of skill, or learning, on the part of such hospital physicians as are usually entrusted with the medication of the insane, is not to be presumed. Because—while it is to be presumed that all hospital physicians are learned and skillful, it is known that they are not, as a class, in possession of secret knowledge of any kind, pertaining to the healing art. And because the general result, or ratio of cures effected, as indicated by hospital reports, is seldom, if ever, *unfavorably* modified by the fact, that young and inexperienced physicians are sometimes placed in charge of large hospital wards.

Nor by the fact that each hospital staff adopts a fash-

ion of medication peculiar to itself. Nor by the fact that homœopathsists, as profoundly convinced of the enormity of administering appreciable medicine to the sick, as some doctors of medicine are of the barbarity of applying appreciable restraint to the insane, are sometimes placed in full control of large hospitals for the insane, and administer only imaginary drugs to their wards.

The fact is, that the cures effected by hospital treatment—if any there be—are not attributable chiefly, if at all, to medication, by whatever method, or whatever drugs.

Knowledge of many sciences, more or less exact, pertain to a thorough medical education. And there are some thoroughly educated physicians, even in America. But therapeutics proper is not a science, exact or otherwise. Nor can it be, so long as the ultimate facts respecting the relation of matter to force, or of function to organization, remain, as now, mysterious.

Excluding medication from our estimate of values, then, in considering hospital treatment of the insane—what other feature is there, of sufficient importance to attract attention, and justify the inference of superiority?

The most prominent of all—restraint. Not this, that, nor the other method, or appliance for restraining the insane—some one or more of which may be objectionable, *per se*—but restraint in a general and comprehensive sense. Restraint—that falls upon the patient as he approaches the hospital, as the shadows fall from its facades and towers upon the lawn beneath. Restraint—that becomes more appreciable when expressed by the attitude of persons in authority, superintendent and subordinates, physicians, attendants, nurses, and others, acting under orders, whereby the patient is placed at once, and unequivocally, upon the footing of a person laboring under some kind of disability—as requiring care and treatment—as an invalid—as insane. A whole system of

restraint, making it possible to secure, for the benefit of the insane; more or less perfectly, by general and special means, persuasive or coercive; (a) regularity of habits, including eating, drinking, bathing, exercise, and rest; and (b) an abandonment of pernicious practices. All of which, to an intelligent observer familiar with the homes and habits of our people—the assumptions, intolerance of environments, insubordination toward authority, and indifference to consequences of conduct, characteristic of the insane; and the attitude of concession, evasion, and downright lying generally occupied by relatives, friends, and physicians, toward the patient, justifies the presumption in favor of hospital, over home treatment, upon which the recommendations of this report are based.

The first step to be taken, then, in the treatment of the insane, if curable, or doubtful, is to send the patient to hospital; a reputable private hospital if circumstances warrant a liberal expenditure of money; to a public hospital if not.

If for any reason this step can not be taken, the next best thing to do, is to convert home into a hospital, by an adoption of hospital methods, and appliances—so far, at least, as to effect a recognition of the fact, on the part of the patient, that he, or she, is regarded, and will be treated, as a person incompetent to direct affairs pertaining to him, or herself; and to secure observance of the more important regulations, respecting conduct, and conditions of person and surroundings, essential to health.

It is true that these recommendations imply coercion rather than concession. It is true, also, that this feature of restraint, characteristic of hospital treatment, is being vigorously assailed, and denounced as “antiquated,” “cruel,” “barbarous,” and “unsuccessful,” by partisans worthy of consideration.

It is claimed, indeed, that such recommendations as I have now made should be reversed, step by step. That

the first thing to be done for insane persons, by way of treatment, is to prevent them from being taken to an insane hospital. And if this, for any reason, can not be done, the next best thing is to convert hospitals into homes—cottages or villas—and abolish all such features and appliances as might, possibly, suggest lunacy to a lunatic, or subordination to the insubordinate.

But such notions of treatment, so far as I am able to analyze them, are more fanciful than wise—more sentimental than judicious.

Sentiment has a high place in the evolution of humanity. It is something more than feeling. It is feeling and imagination integrated, organized, sometimes refined. But sentiment is not the highest intellectual attainment of mankind.

It is sweet and gentle to be interested, sentimentally, in the condition and welfare of the depraved and vicious—who are depraved and vicious because of an arrest of human development short of the higher and more complex capabilities that are essential to high, complex intellectual perceptions. Yet there is danger of sacrificing the best interests, not only of society, but of the vicious themselves, by permitting our conduct toward them to partake more of sympathy than of judgment.

So, too, it is generous and noble to be engaged in protecting the insane, and preventing insanity; but such ends can not be accomplished by mistaken kindness toward the one, or false pretenses respecting the other, object.

Nature, of which we are a part, yet heed so little, is full of suggestions on this, as on all other subjects, were we but wise enough to see and comprehend them. For example—the conditions of our being are all coercive. Our environments are all restraints, imposed by nature. This world, in which we have our being and prate of liberty, is but a grand old hospital for the insane; and we are, all of us, but so many inmates, suffering limitations,

each in accordance with his own infirmities, incompetencies, or delusions. Incompetency throughout the universe implies subordination, from which neither love nor pity can redeem it.

The question of coercion, then, as applicable to the insane, is a question of capability on the part of the patient; a question to be determined—each case by its own conditions. Needless restraint, or offensive appliances may be cruel. Failure to restrain, if circumstances require restraint, may be more so.

True egoists, in the technical sense of the word, are the insane, for the most part. Suffering deterioration of the highest and most complex capabilities, in accordance with the law of retrogressive order, soon or late they fall below, if indeed they ever occupied, the true plane of altruistic perceptions, and hence become comparatively incapable of present forbearance, subordination, or self-sacrifice, for the good of others, or of self, prospectively.

Children or savages, according to the degree of deterioration effected by disease, or the violence of activities manifested, are the insane.

As children or savages, according to conditions, tenderly or rigidly, they must be treated, for their own good and the welfare of society.

In addition to the general restraint characteristic of hospital treatment, there are three methods in common use, by which the insane may be coerced—classified, because of the means used, as Moral, Mechanical, and Chemical.

Of moral restraint little need be said. It suggests itself, and should always be adopted, and its elements exhausted, before any other is thought of.

Moral restraint fails, however—sometimes because of the incompetency, or impatience, of persons to whom its application is entrusted. More frequently because of the impairment of organs, on the part of the insane, upon which reflex mental capabilities depend.

The popular notion that some persons are gifted with special power by which the insane may be fascinated and controlled, is erroneous. As much depends upon the peculiarities of the insane themselves as upon the characteristics of persons attempting to control them. The insane sometimes contract, unaccountably, sudden likes or dislikes for those with whom they come in contact, and resist, or yield to, them accordingly.

Moral restraint should never be permitted to fail because of needless association of patients with nurses, or others, toward whom they entertain delusive prejudices of a disagreeable character.

Argument, as a general thing, is unavailing as an element of moral restraint in the treatment of the insane.

A clear, firm, kindly statement of facts, to which may be added advice and persuasion, should limit verbal communications with the insane for restraining purposes.

The insane should be spoken to, under all circumstances, candidly and truthfully, if at all. There is no excuse for deception or prevarications. Silence is a far better alternative whenever the truth had better not be spoken.

Granting and denying privileges, as incentives to self-control, pertain to this method of restraining the insane. In the treatment of the incurable, especially of such as have been repaired, but not restored; whose mental capabilities are permanently deteriorated, but not disorderly; this practice is effective and appropriate.

Rewards and punishment are, in fact, the chief elements of moral restraint by which lower human and higher brute beings are ever influenced. He may be said to have attained a lofty intellectual eminence who can see clearly other data of ethics than rewards and punishments, immediate or prospective.

• But in the treatment of other insane persons, all such as, by reason of disease, are dominated by delusions—incapable of reflex ideation, pre-occupied by concepts

born of centric excitations, no real good can be accomplished by such means.

Music, lectures, religious exercises, picture-shows, all of the so-called amusements that figure conspicuously in hospital reports, are subject to the same general criticism.

Mechanical restraint consists of and embraces all force applied from without, by which bodily motions are limited. The means used are strong rooms, protection beds, camisoles, muffs, mittens, straps, wet or dry packs, and the hands of attendants.

A formidable array of implements, truly; but fortunately for practitioner and patient, like bottled medicines on the apothecary's shelves, it is never necessary to prescribe all of them at the same time for every patient under treatment. In a thoroughly equipped hospital, as supplementary to the general restraint alluded to, the necessity of special restraint has long been regarded as exceptional, and by some as altogether avoidable. Yet each of these appliances has its specific adaptableness to certain cases, and the demand now being made upon hospital physicians that all, or the greater part of them, be unconditionally rejected and destroyed, because of a suppositious temptation to prescribe them needlessly, if at hand, is based upon a pretext as unmanly as it is unreasonable. The same pretext, if valid, would compel the removal of all doors from private rooms, in which patients may be incarcerated—destroy all bath tubs, broom handles, mopsticks and towels, manacle the arms and legs of all nurses, and banish all drugs from the face of the earth; so frequently have all these been subjects of abuse, so surely will they continue to be misused under some circumstances.

The only pretext worthy of consideration for such a demand is the assumption that it is better for the insane patient to exhaust structural capability by expressing disorderly activities, than it is to conserve morbidly excited energy by restraint.

This is debatable ground. But, as the assumption can not be successfully maintained, nor perhaps refuted, by physiological citations, the questions involved can only be settled by clinical observations—and it becomes those who make the assertion, to show, by unsophisticated statistics, that there has been an increase in the ratio of recoveries of insane persons treated, corresponding to the ratio of disuse of special restraint. So far as I know this has not been done; nor can it be. An opposite conclusion indeed might be drawn from the appearance that the ratio of recoveries of the insane is not now equal to the ratio of forty years since, either in this country, or in Europe.

It may, also, be affirmed in behalf of special restraint, in the treatment of the insane, that in many instances, while it may not be positively beneficial, yet if not positively harmful, to the patient restrained—the benefit to other persons may justify the practice.

For myself, while I do not believe it best to suppress all motion expressive of morbid excitation, I do believe it best to so limit bodily motion as to prevent structural exhaustion, even though it should imply the occasional use of mechanical appliances. I say this in the face of the fact that it is claimed by eminent authority\* that it is “*eminently unphysiological to restrain mere outward muscular movements while the motor energy is being all the while generated in the brain convolutions,*” because I believe expression, muscular expression even, is so intimately associated with the cerebral energization, that the one condition may be, to some extent, affected, and modified by the other. Certainly this is so, in all physiological conditions—and we are compelled to treat pathological conditions in accordance with physiological principles. Motor energy, however structurally eliminated, implies blood, in a state of activity; and is strong

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\*Clouston—Mental Diseases, p. 112.

or feeble in accordance with the condition of structure, and the quality and quantity of pabulum furnished. The circulation of blood through the brain can be almost if not quite doubled by muscular motion. To suppose that motor energy will, or can be generated in the brain convolutions as rapidly when the body is in a state of comparative repose, as when it is in a state of general activity, is, it seems to me, unphysiological, however it may appear to others—and the announcement of a distinguished author\* to whose pages, full of life and character, it is a delight to turn after the weariness inseparable from serious contemplation of some contemporaneous publications, that *“our great efforts in the treatment of such cases (acute maniacs) now are to find suitable outlets for the morbid motor energy, to turn the restless, purposeless movements into natural channels, to get the patient to dig and wheel barrowes soon, and to walk long distances, instead of shouting and gesticulating,”* does not seem to me to be in compliance with any physiological demand looking toward cure, or conservation of energy, otherwise than as such change of direction of morbid energies into involuntary channels is, although effected by persuasion, in the nature of restraint, and ultimates in an actual reduction of muscular motion. And, if it be true, as stated by this same broad and liberal author that this turning of motor energy from purposeless movements into wheeling barrows *“saps and exhausts the morbid energy and excitement, producing healthy exhaustion and sound sleep, vigorous digestion and healthy excitation of the skin, the glands, and the excretory apparatus generally,”* one is left still in wonderment that the ratio of recoveries is so little affected by such treatment—or indeed that any persons so treated should fail to recover.

But even this author confesses all that could be desired

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\*Clouston—Mental Diseases, p. 142.

in this argument by saying "*I have seen cases where restraint had to be applied to prevent the patient exhausting or hurting himself, but they are amazingly few in a well equipped asylum, with large grounds, a farm, good attendants, and plenty of them, and a padded room.*"

Conservation of energy, with "incidental protection," being the chief ends of special restraint, in the treatment of the curable insane, my belief is that the "protection bed" properly constructed and furnished, is the least objectionable, and most generally applicable, mechanism for restraining such insane persons as require more than partial or momentary restraint of any now in use. It is preferable to a strong room, because it really limits the motions of the patient's body, instead of simply hiding the patient from public observation. It is better than the camisole, or pack, because it limits the general, without embarrassing the special, motions of the body; and does not beget resistance by irritating contact with the person. The incidental protection afforded by it, is all that can be desired.

For partial, or mere temporary restraint, other mechanisms are more appropriate than the protection bed. Any one of those mentioned, for other than momentary restraint, is preferable to manual applications.

In saying what I have on this subject, I have not been unmindful of the fact that grave physiological objections have been urged against the use of the protection bed. It has been asserted, indeed, that cerebral hyperæmia, and consequent maniacal excitement, and insomnia, are increased, if not induced, by gravitation of the blood to the head, as a consequence of the recumbent position necessarily occupied by the patient thus restrained.

The facts that cerebral hyperæmia and maniacal excitement are not, necessarily, concomitant:—that recumbency and sleep have been forever associated in the

natural history of man—and that a general retardation of the motion of blood in the veins, and mitigation of the heart's force, resulting from muscular repose, more than compensate any possible influence of gravitation, seem to have been overlooked, or without significance, in this estimate of causes and effects.

There are persons, however, so constituted, that they are never embarrassed by, nor for the want of, facts, when presenting their view of any given subject.

Chemical restraints consist of all such substances as are capable, when ingested, of modifying or suspending the function of sensory or motor organs. There are many known substances thus capable; first of stimulating, and subsequently of paralyzing such organs.

These substances are not capable of entering into animal organization as nutrients: Yet they influence, when present, both constructive and destructive metamorphoses incidental to the evolution and dissolution of animal tissues. Why? Or how? I do not know. By slowing or hastening these physiological changes? It may be—still the final interrogatory is not answered.

Among the more reputable of these drugs are Opium, Chloral, Alcohol, Hyoscyamus, Conium, Cannabis Indica and the Bromides.

When given to restrain, specifically, they should be administered in quantities sufficient to effect the purpose fully and promptly. Inadequate doses not only disappoint expectations, but increase rather than diminish the morbid activities which they were intended to quiet. The necessities of any one person, in this respect, can not be measured accurately by the requirements of others. The quantity of medicine appropriate for each should be ascertained by careful preliminary experiments.

As a sleep-compeller, within the bounds of safety, chloral stands at the head of the list of chemical restraints. Its effects are immediate, persistent, seldom disagreeable,

and pass away without alarming symptoms. Frequent repetition of its use, for a protracted period, is not, however, beneficial in the treatment of curable persons; and it should not be depended upon at all, in the treatment of the melancholy, or suicidal. Not because of inefficiency as a restraint, in such cases—but because of its tendency to impoverish rather than to enrich the brain.

The bromides are much less actively coercive than chloral. They are very useful, however, when judiciously prescribed. They are calmative and depressant, rather than hypnotic; and, also, impoverish rather than enrich cerebral structures.

Opium has no rival in nature as a medicine. No other drug is so capable of modifying the conditions of consciousness as to relieve from pain without affecting complete unconsciousness. As a sleep-compeller merely, it is not as safe as chloral. But in the treatment of the insane, especially of the depressed, and suicidal, it is the one remedy that has maintained its good repute for many centuries.

Alcohol resembles opium in its general effects, applicability, and usefulness, as a medicine. It exerts a well marked influence over both constructive and destructive activities, affecting the various organs of a man.

With these four general agents, the skillful practitioner can accomplish all that can be accomplished by chemical restraints in the treatment of the insane. It is needless, therefore, to discuss the qualities of other drugs of the class, of less merit, or reputation. As an attorney at law is bound to produce his best evidence in the trial of a cause in court; so the medical practitioner should feel obliged to prescribe his best remedies in the treatment of the sick. He needs but few, if they be efficient, and only embarrasses himself with more than are required to meet necessities.

That drugs capable of obliterating consciousness and

paralyzing motion should be prescribed with care and circumspection, need not be asserted.

That medicines capable of banishing pain, without immediate danger to life, will be resorted to, needlessly and injudiciously, may be reasonably anticipated.

That the restraint effected by any drug more than simulates natural repose, is not probable. The unconsciousness effected by chloral, opium, or alcohol, as compared with natural sleep, is neither balmy nor restorative. Yet neither of these facts, nor all of them, would justify the inhibition of their use, nor furnish a manly pretext for unfavorable criticism of their merits. The quack may be despised, or the fool pitied, who misuses them—but that they have contributed largely to the comfort of mankind, if not to the longevity of the race, can not be successfully disputed.

Without such drugs, indeed, the practice of medicine would seem to me—however it might appear to others—to be as comfortless to patient and physician, as would be, to penitent and priest, the ceremonials of religion with the consolation of promised forgiveness and salvation all left out.

The clinical history of an insane person that indicates and justifies, special restraint, includes:

- (a.) Excessive and protracted voluntary muscular motion, threatening exhaustion. •
- (b.) Paroxysmal violence, endangering self or others.
- (c.) Persistent denudation, and exposure of person.
- (d.) Self-abuse, sexual or mutilatory. • •
- (e.) Destructiveness, general or special.
- (f.) Sleeplessness and somnambulistic states.

The conditions (b) and (f)—paroxysmal violence, and insomnia—call for chemical restraint. All other conditions, *moral restraint having failed*, are best met by mechanical appliances; the rule of practice being for all, not to persist in the use of any means found by experi-

ment to increase, rather than to diminish, morbid manifestations, which it is desirable to suppress.

Medication of the insane, for other purposes than the restraint of morbid activities, does not differ from that pertinent to the treatment of other diseased persons. It is less satisfactory perhaps, because, apparently, less successful; consequently affording less room for self-deception respecting the curative power of drugs, or the importance of the physician's office in prescribing them. The insane, too, are neither hopeful nor grateful, because of the physician's efforts for their cure while under treatment; however they may be after, if restored. So that the practitioner is deprived of the aid of the subtle influences of hope, expectation, and faith in medicine, that are supposed to assist wonderfully, when properly enlisted, in restoring the body from disease. It is needless, perhaps, to say in this connection that all medication should be directed with special reference to known or supposable conditions of the body—with the distinct understanding that it is better—far better—to “throw physic to the dogs,” than to be aiming it at a “mind diseased,” without regard to physical conditions.

The primary and consecutive physical lesions of which mental disorder may be an ultimate manifestation, are numerous, and various, but may be appropriately classified under two heads, viz: *Lesions of construction and Lesions of destruction*. Of some of these lesions much is known—and more may be knowable. Yet there are certain ultimate facts pertaining to the relationship of force to matter—of protoplasm to structure—and of structure to function—that may constitute the *noumenon* that will forever baffle us as physiologists, psychologists, and psychiatrists as well. Of the tree of knowledge we have partaken—but the tree of life is still guarded against our invasion.

We can however, and it is important that we should,

as a guide to prognosis as well as treatment, differentiate lesions of construction from lesions of destruction, with commendable accuracy.

The activities of the one class of lesions always precede, and, if not arrested, culminate in, the activities of the other; and both often exist at the same time, in the same individual, after such culmination.

The clinical history of constructive lesions embraces *inanition, indigestion, inassimilation and intoxication*, represented by disorder all along the line, from the ingestion of crude materials to the dissolution of organized structures; by which the natural balance between protoplasm, structure and function, is inevitably disturbed.

The history of destructive lesions embraces the *various cachexies: cancerous, syphilitic, tuberculous, &c., atrophy: atheromatous and other degenerations; and all inflammations*.

These lesions, when recognized, should indicate their own treatment. The dyspeptic, tuberculous, syphilitic, toxæmic lunatic, differs only from any other dyspeptic, tuberculous, syphilitic or toxæmic patient, pathologically, in the matter of localization of morbid activities; the brain of the lunatic, or some of its appendages, always being affected, while the brains of others may be exempt.

The indications of treatment, in all lesions of construction, call for NUTRITION AND DEPURATION. Nutrition, that constructive activities may not culminate in destructive activities because of protoplasmic or structural exhaustion—and depuration, that nutrition may not be embarrassed by the presence of effete and toxic accumulations.

The remedies called for by constructive lesions are *nutrients and evacuants*.

The remedies indicated by lesions of destruction are called *tonics, stimulants and alteratives*.

When lesions of construction coexist with lesions of

destruction, a combination of remedies may be appropriately prescribed.

Have we any nutrient medicines?

If medicine, as defined by Webster, is "any substance administered in the treatment of disease," we have. Fresh beef, milk, eggs, meal, water and air, are medicines *par excellence*—nutrients of the first order. Salt, sugar, fruit, acids, and oils, are adjuvants of great utility. Some bitter or carminative extracts, spices, wines and other table beverages, may promote nutrition under some circumstances; but they are not nutrients. No drugs proper can be classed as such. Many proprietary preparations of medicinal food—vegetable and animal extracts—pepsins and peptonoids—grace the apothecary's shelves and the advertising pages of our medical journals, but with a few exceptions they can not be trusted as nutrients, or aids to nutrition.

No definite prescription of nutrient remedies to meet hypothetical conditions, need or can be, profitably, made. Yet a nice discrimination of needs, and adaptation of food medicines to various and sometimes obscurely indicated conditions, effected by constructive lesions, are the most important feats that the medical practitioner will ever accomplish in the practice of medicine. To this end he should study cookery as well as pharmacy, and patronize the kitchen in preference to the drug store.

There are many depuratory agents, drugs proper, of the emetic, cathartic, diuretic, or other variety of deobstruents. But of all known depurators, water is the one universally applicable and indispensable agent.

Multitudes of men and women, in the midst of luxury, suffer, die, because of their habitual neglect to cleanse themselves, inside as well as out, with this universal solvent and detergent.

Water is nature's agent, and effects its ends while acting in harmony with all natural processes.

Drugs are artificial evacuants, and accomplish what they do, I know not how; but possibly, because of their own offensiveness, by arousing the various organs of elimination, excretion, and defecation, to unusual, even violent activity, for their own expulsion; whereby other less offensive matters that may have accumulated in the body are carried out also.

That much good has been, and may be, accomplished by such means, even if the theory suggested be correct, is beyond question.

It is well to remember, however, that in using them, like a spur to a jaded horse, they should only be resorted to in cases of emergency, for temporary purposes. They can not be depended upon to take the place of natural agents.

The practitioner has a large assortment of drugs of this class to select from, but he who knows how to use calomel, ipecac, and the potassic salts, can accomplish all that can be accomplished in the line of their usefulness.

In the treatment of the insane, if under absolute control, the use of water should soon obviate the necessity of resorting to drugs as depurators at all.

A proper use of water, in the treatment of the insane, implies something more than filling a pitcher, bucket, or tank, periodically; and leaving it within reach of patients through the day: or ordering a general bath Wednesdays or Saturdays—afternoon. It implies, indeed, knowledge, tact, sensibility, and patient watchfulness, on the part of those directing its use. If the sane can not be trusted to use water intelligently for their own good—how can the insane be trusted?

Neither can general attendants or nurses be trusted, under all circumstances, to do their whole duty; however well instructed in a general way. The best of them require constant supervision, and special instructions to meet the necessities of special conditions.

Eternal vigilance is not only the price of liberty—it is the price of success, in the treatment of the insane.

Observant of everything, the hospital physician should be particularly sensitive to, and careful respecting, little things—things that are likely to be overlooked, or disregarded, as “little” by the insensitive, indifferent, ill-bred. And there are such—I grieve to say so—in this broad land of freedom and democracy—persons, for example—I have seen such prescribing for the sick; who would smile incredulously, or derisively, at the protest of a patient alleging inability to drink from a cup, or dip from a bucket, used in common by the patients of the hospital ward—or complaining of loss of appetite, and inability to eat, because of offensive odors, or the disgusting appearance or habits of table associates. I have known persons, also employed in hospitals, in official positions, who could not comprehend the delicacy of feeling that would cause a person of refinement, even when insane, to shrink from bathing in company—two or more persons occupying the same tub, and water, and using the same towel—notwithstanding the impatience of attendants required to bathe a certain number of persons within a given number of hours. But such persons, it is needless to say, are unfit for hospital service; and such “little things” are too important to be pooh poohed, or neglected, in the treatment of the insane. They are quite as important, indeed, to be known of, and attended to, as is the occasional necessity for, and skill in, the use of the stomach tube for involuntary alimentation; or the voting qualification of appointees of political hospital-Boards.

A continuously full supply of air is essential to purification of the human body. Nature cremates—oxidizes that which has served its purposes in organization—reducing it to more primitive conditions. A certain amount of motion contributes, also, to the changes involved in the processes of nutrition and depuration.

Exercise in the open air, is therefore, a natural suggestion of great value, which should be acted upon, as not only wise, but authoritative. When, how, and to what extent, exercise should be performed, are questions to be determined by special considerations—requiring knowledge and discretion for their solution.

Massage, intelligently prescribed and performed, is useful, beyond question, for patients incapable of voluntary exercise. But, like electricity, in the hands of innocent, or designing, ignorance, it is more likely to be harmful than beneficial.

Occupation—labor, study—are being recommended and urged, as remedial agents in the treatment of the insane. For the custodial classes including the convalescing, there can be no doubt of the propriety and usefulness of such elements of treatment

By, or with, the methods and means thus suggested, and variously adapted to the wants of individuals; together with all of the details of intelligent nursing; all of the insane that are practically curable; if treated, may be expected to recover within a reasonable period—the greater number within six months from the beginning of treatment. Possibilities, however, remain for a long time, in some instances, to encourage the practitioner. In all cases, indeed, until constructive disorder shall have culminated in destructive processes—after which the patient may be pronounced decisively incurable. This proposition, possibly, may not pass unchallenged.

Are there not, also, reconstructive activities and processes? May not destruction be arrested? May not injured structures be repaired? Restored?

Arrested? Yes. Repaired? Yes. Restored? Never. Destructive processes are ~~not~~ only arrested by an interposition of more stable, hence less complex, structures: accomplished by reconstructive activities—never by reproduction of original tissues—however slight the

deterioration. The ratio of stability of all organized bodies is inverse to that of their complexity.

Of medicines considered appropriate for the treatment of lesions of destruction, there are, also, many. Iron and arsenic are the most useful tonics. Cinchona and nuxvomica are admirable stimulants. Iodine and mercury have long maintained their reputation as alteratives. With these representatives of their classes, the skillful practitioner may consider himself fully equipped. That the action of these, or any other drugs, is directly curative, or accomplishes more than an occasional turning of the balance of vital activities in favor of reconstruction, is not to be presumed.

A happy response of the ever delicate and oscillating scale of organization to medical influence, that occasionally rewards the efforts of the rational empiric, is the one fact that justifies continuation of experiment in the use of drugs, and saves the more intelligent physician from out-and-out infidelity respecting their virtues as healing elements, in the practice of his profession.

The therapist is but a helper after all. He can not create. He cannot renew. The boasting Paracelsus died. So do we all. We can modify physical activities to a limited and always uncertain degree, by affecting physical states, but we can not divert natural processions by any possibility from lines established by material conditions.

Were we more accurately and fully informed respecting the relations of structure to activities and phenomena; general and special; and the definite relation of drug-force to constructive, destructive, and re-constructive activities; we might hope to effect much more by medication of the insane than is now possible.

All pretense of scientific psychiatry must rest upon such a basis of information.

If any one is disposed to criticise his own pretensions as a psychiatrist, in the light of this fact, let him do so. There is consolation for him, however, and for us all, in

the fact that rational empiricism is but one remove from science—that it is the ground from which science springs—and that we, as tillers of this ground, have cleared the field which psychology and psychiatry may some day occupy as sciences, of much rubbish—the *debris* of ages—and have sown some seed that even now is germinating, with promise of future growth.

And so, having sketched the outlines of that which appears to me, in the light of present knowledge, to be a rational treatment of the insane, without alluding to obsolete, or discussing doubtful, practices; knowing full well how limited are its recommendations and how unassuring its promises, I beg leave to submit this report, and ask that my learned colleagues be held not responsible for any of its deficiencies or errors.

To which I desire to add the confession, that after forty years devotion to the study and practice of medicine—fifteen in constant contact with the insane—having experimented through a wide range of theories and practices, from the rationalism of SYDENHAM to the transcendentalism of HAHNEMANN—I am less confident now of my ability to cure, or to materially aid in the cure of, diseased conditions, than I was in the earlier years of my apprenticeship.

I am also convinced that the more one knows physiologically, and historically, of himself—and of all other beings of the kingdom of nature of which he is a part—and the clearer and more comprehensive his perceptions of the relations of parts to wholes—of phenomena to mechanisms, and of sequences to antecedent conditions—the more intelligent will be his observations of the natural history of disease—the greater will be his confidence in the unaided activities of that “efficient cause” which is associated with material conditions—and the less arrogant will be his pretensions as a healer of disorders, of whatever character. And if not finally devastated by

the skepticism that comes of unlimited liberty of investigation associated with limited capabilities of comprehension; a disaster to which small men are liable; the more and more will he become impressed with the importance of generalizations of knowledge—and the less and less will he be influenced by the merely notional, sentimental, or fashionable, in the practice of medicine.





